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Office of Administrative Law Judges
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Issue Date: 24 January 2005

Case No. 2003-BLA-5805

In the Matter of:
DOYLE JAMES ROBERTS,
Claimant,

v.

SHAMROCK COAL CO., INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

APPEARANCES:
Edmond Collett, Esq.
On behalf of Claimant

Lois A. Kitts, Esq.
On behalf of Employer

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On April 21, 2003, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 46).[2] A formal hearing on this matter was conducted on November 19, 2003, in Hazard, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the Miner has pneumoconiosis as defined by the Act;

3. Whether the Miner's pneumoconiosis arose out of coal mine employment;

4. Whether the Miner is totally disabled;

5. Whether the Miner's disability is due to pneumoconiosis; and

6. Whether the Claimant has two dependants for purpose of augmentation.

(DX 46).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Doyle Roberts ("Claimant") was born on February 24, 1948; he was 55 years-old at the time of the hearing. (DX 2; Tr. 16). He completed the ninth grade. (DX 2; Tr. 18). On his application for benefits, Claimant stated that he engaged in coal mine employment for 30 years. (DX 2). Claimant's last coal mine employment was as a light-house attendant, where he worked in the mine office taking care of all of the lights, sweeping and mopping floors, answering phones, dispatching, and watching the monitor. (DX 4, 26; Tr. 22). Claimant described the physical requirements of the work to include sitting for five hours per day, standing for five hours per day, and lifting 50 pounds several times per day. (DX 4). He also described the position as dusty, but not as dusty as working underground. (DX 26; Tr. 24). Claimant had

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing the Employer withdrew the length of employment issue, stipulating to at least 30 years of employment in or around one or more coal mines. (Tr. 16).

previously worked as a shuttle car operator, a miner helper, a coal shoveler, and a coal shooter. (DX 4, 26; Tr. 20). Claimant last worked in and around coal mines in 1999 when he was laid off by his employer. (DX 2, 26; Tr. 25). He does not receive Social Security Disability benefits, (DX 26; Tr.26), and he has never filed for State Black Lung benefits. (DX 2, 7).

Procedural History

Claimant filed a claim for benefits under the Act on March 30, 2001. (DX 2). On January 14, 2003, the District Director, Office of Workers' Compensation, issued a Proposed Decision and Order Denial of Benefits. (DX 41). The Director found that while Claimant suffers from pneumoconiosis and his pneumoconiosis was caused, at least in part, by work in coal mines, Claimant is not totally disabled due to pneumoconiosis. (DX 41). On January 21, 2003, Claimant requested a formal hearing. (DX 42). On April 21, 2003, this matter was transferred to the Office of the Administrative Law Judges. (DX 36).

Dependency

On December 4, 1971, Claimant married Martha Lou Maggard. (DX 2, 8, 26; Tr. 17). I find Claimant's wife, Martha Lou, is a dependant for purposes of augmentation.

Claimant has a daughter, Valerie Page Roberts, who was born on October 4, 1982. (DX 2, 9). On his application for benefits he marked that she was between the age of 18 and 23 and attending school. (DX 2). Claimant also submitted a signed statement regarding student attendance that alleges that his daughter was enrolled at Leslie County High School at the time he filed for benefits, that she would be continuing at least one more year, and that she had been accepted, or applied for admission to Alice Lloyd College. (DX 10). At the July 2, 2001, deposition, Claimant stated that his daughter was 17, attending high school, and would be attending Alice Lloyd in the fall. (DX 26).[4] At the 2003 hearing, Claimant testified that his daughter had graduated high school and was enrolled in college on a full-time basis. (Tr. 31-32). Also, she has had an apartment for the semester preceding the hearing, but stays with Claimant on weekends and in her own apartment on week nights. (Tr. 31-34). Furthermore, Claimant testified that he has claimed his daughter for tax purposes until 2003, but would not be claiming her in 2003 so that she would qualify for grant assistance. (Tr. 33). Claimant clarified that Valerie was a dependent in March 2001, but has not been his dependant since Fall 2003. (Tr. 35). She is training to be a dental hygienist. (Tr. 32).

The applicable provisions of § 725.209 state that a beneficiary's child will be determined to have been dependant if the child is 18 years of age or older and is a full-time student under 23 years of age and has not completed 4 years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at an institution which is a technical, trade, or vocational school. Section 725.210 states that augmented benefits payable on behalf of a child shall begin with the first month in which the dependent satisfies the condition of relationship and continues through the month before the month in which the dependant ceases to satisfy these conditions.

[4] Claimant reiterated his daughter's status in his response to Employer's interrogatories. (DX 27).

Valerie would have been 18 years old in October 2000, or six months before Claimant applied for benefits. Contrary to Employer's contention in its contested response to the Director's Proposed Decision and Order, (DX 45), Claimant has submitted a birth record for his daughter. (DX 9). Also, while Employer's contention that Claimant has submitted no record of student status, is accurate, (DX 45), Employer has not presented any argument or evidence that contradicts Claimant's consistent statements concerning Valerie's status as a high school student in 2001, or her status as a full-time college student pursuing a vocational degree in dental hygiene in the latter half of 2001 through 2002. As a result, I find Claimant's application, signed statement, deposition testimony, and hearing testimony to be credible, and therefore find Valerie to be a dependant for purposes of augmentation of benefits according to § 725.209.

Concerning duration of benefits, while Claimant testified that his daughter had her own apartment for the Fall of 2003 semester and he no longer considered her a dependent, there is no evidence or testimony identifying the specific month when Valerie moved out. Therefore, aside from educated speculation, there is nothing to base my decision as to which month in the Fall of 2003 to consider dependency to come to an end. Claimant, however, also stated that he was not going to claim his daughter for tax purposes in 2003 so that she could qualify for grant assistance. As a result, under the requirements of §725.210, I am able to determine a dependency cutoff date of December 2002. Therefore, I find that Claimant's daughter, Valerie Page, was a dependant for purposes of benefit augmentation from March 2001 through December 2002.

Finally, at the hearing Claimant also testified that his grandson, Connor Bray, lives with him. (Tr. 17). While Claimant financially supports his grandson, providing food and shelter, he confirmed that he has not legally adopted the child. (Tr. 17-18, 31). Since Claimant is not the natural parent, adoptive parent, or stepparent of Connor Bray, and the courts of the Commonwealth of Kentucky have not found Connor to be Claimant's child, Claimant has not established a child relationship with Connor Bray under §725.208. Therefore, I find that Connor Bray is not a dependant for purposes of augmentation.

I have found Claimant's wife, Martha Lou, to be a dependant for purposes of augmentation. I have found his daughter, Valerie Page to be a dependant from the time Claimant filed his application until December 2002. Finally, I have found Claimant's grandson, Connor Bray, not to be a dependant for purposes of augmentation. Therefore, from March 2001 through December 2002, I find that Claimant has two dependents for purposes of augmentation, and from January 2003 through the date of the hearing, I find that Claimant has one dependant for purposes of augmentation.

Timeliness

Under Section 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. Mr. Roberts did not testify as to having been told by a physician that he was totally disabled due to pneumoconiosis prior to 2001. Also, the date of the Claimant's first examination of record to diagnosis Coal Workers' Pneumoconiosis ("CWP") is

Dr. Baker's report dated February 24, 2001, only one month prior to Claimant's application for benefits under the Act. (DX 12). Because the record contains no evidence that claimant received the requisite notice more than three years prior to filing his claim for benefits, I find that this claim was timely filed.

Length of Coal Mine Employment

At the July 2, 2001 deposition Claimant stated that he had worked in coal mining for 28 years. (DX 26). The Director, in a Proposed Decision and Order dated January 14, 2003, determined that Claimant has 27.5 years of coal mine employment. (DX 41). At the hearing Claimant testified that he worked 25 years underground and as much as six additional years as a light house attendant. (Tr. 19). The parties have stipulated that the Claimant worked at least 30 years in or around one or more coal mines. (Tr. 16). I find that the record supports this stipulation, (DX 3-6), and therefore, I hold that the Claimant worked at least 30 years in or around one or more coal mines.

Claimant's last employment was in the Commonwealth of Kentucky; (DX 3), therefore, the law of the Sixth Circuit is controlling. [5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Shamrock Coal Co., Inc. as the putative responsible operator because it was the last operator to employ Claimant for a year. (DX 18). Shamrock Coal accepted liability on its amended Operator Response dated July 6, 2001, (DX 25, 34-35), and did not contest this issue at the hearing. (DX 46). After review of the record, I find that Shamrock Coal Co., Inc. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i),

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Imtiaz Hussain to provide his Department of Labor sponsored complete pulmonary examination. (DX 11, 47). Dr. Hussain conducted the examination on July 11, 2001. I admit Dr. Hussain's report under § 725.406(b). I also admit Dr. Sargent's quality-only interpretation of the chest x-ray under § 725.406(c). (DX 17).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 3). Claimant designated Dr. Glen Baker's complete pulmonary evaluation conducted on February 24, 2001. Claimant also included an x-ray interpretation of the August 16, 2001 film by Dr. Alexander, as rebuttal evidence. Finally, he included Dr. Baker's records from October 15, 2002 through April 1, 2003, as hospitalization records and treatment notes. Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3). Therefore, I admit the evidence Claimant designated in its summary form.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 15). Employer designated Dr. Rosenberg's complete pulmonary examination conducted on September 17, 2003. Dr. Rosenberg's medical narrative for that date included a review of his medical examination conducted on August 16, 2001, so the September 17, 2003 report counts as two medical narrative reports for the purpose of determining admissibility under the limitations of § 725.414(a)(3). Employer included Dr. Poulos' reading of the August 16, 2001 x-ray, and Dr. Dr. Poulos' rehabilitative re-reading of that x-ray. Also, Employer included a reading of the February 24, 2001 x-ray by Dr. Wiot and Dr. Poulos' reading of the July 11, 2001 x-ray, as rebuttal evidence. Next, Employer included Dr. Rosenberg's PFT and ABG studies dated August 16, 2001 as initial evidence, and reviews by Drs. Vuskovich and Fino of the PFT and ABG studies conducted by Drs. Hussain and Baker, as rebuttal evidence. Finally, in support of its submissions, Employer included depositions from Drs. Poulos, Rosenberg, and Fino. Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the evidence Employer has designated in its summary form.

X-RAYS

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician / Credentials**	**Interpretation**
DX 12	2/24/01	2/24/01	Baker[6]	1/2 pp Film Quality 3
EX 6	2/24/01	9/10/03	Wiot, BCR[7], B-reader[8]	Negative

[6] At the time the x-ray reading, Dr. Baker did not hold B-reader x-ray interpretation credentials. But the June 7, 2004 "B-reader" list states that he was a B-reader from February 1, 1993 to January 31, 2001, and again from June 1, 2002 to present. Also, he is listed as an A-reader from February 1, 2001 to May 31, 2002.

				Film Quality 3
DX 16	7/11/01	07/11/01	Hussain	2/3 ps
DX 17	7/11/01	07/31/01	Sargent, BCR, B-reader	Quality only
DX 40	7/11/01	06/19/02	Poulos,[9] BCR, B-reader	Negative
DX 33	8/16/01	08/24/01	Poulos,[10] BCR, B-reader	Negative
DX 38	8/16/01	06/08/02	Alexander, BCR, B-reader	2/1 pq
EX 14	8/16/01	10/24/03	Poulos, BCR, B-reader	Negative
EX 10	9/17/03	09/17/03	Rosenberg, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 12 2/24/01	Not listed/ Not listed/ Yes	53 65”	3.20	3.85	118	83	No[11]
DX 15 7/11/01	Good/ Good/ Yes	53 65”	3.45	4.16	90	82.9	No[12]
EX 1 5/7/01	Fair-Poor[13]/ Not listed/ Yes	53 65”	2.14 3.35*	3.5 3.9*	115.9 111.5*	61 85.8	No No*

[7] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[8] A “B” reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[9] Dr. Poulos was deposed by the Employer on November 7, 2003, when he repeated the findings of his earlier written report. (EX 16).

[10] At the November 7, 2003 deposition, Dr. Poulos repeated the findings of his earlier written report. (EX 16).

[11] Dr. Fino, an internist and pulmonologist, stated that the PFT values were within normal limits. (EX 8-9). In the deposition on December 8, 2003, he stated that while Claimant did not give maximum effort, the recorded values showed Claimant’s minimal lung function, and were valid to the extent that they are acceptable to be used to determine if there is no impairment or disability. (EX 18: 7-8). Based on the recorded values, Dr. Fino opined that Claimant does not have any respiratory or pulmonary impairment or disability. (EX 18: 9).

[12] Dr. Vuskovich, a physician Board certified in occupational medicine, stated that this study was valid and within normal limits. (EX 12-13).

[13] In his narrative report, Dr. Rosenberg stated that Claimant had difficulty performing this test. (EX 10). He stated that the pre-bronchodilator results revealed no presence of restriction, but the flow rates could not be used to assess any degree of airflow impairment, and the flow volumes demonstrated incomplete and inadequate effort. The post-bronchodilator results, however, showed a little bit more consistency, but still not maximal in degree. Nevertheless, Dr. Rosenberg found no evidence of obstruction or restriction after post-bronchodilator.

EX 10 9/17/03	Good/ Good/ Yes	55 65"	3.51	4.26	122	82	No

* post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 12	2/24/01	37	75	No[14]
DX 14	7/11/01	32.8 33.6*	71 77*	No[15]
EX 4	8/16/01	34.4	75.3	No
EX 10	9/17/03	32	81.4	No

*post-exercise values

Narrative Reports

Dr. Glen R. Baker Jr., an internist and pulmonologist, examined the Claimant on February 24, 2001. (DX 12). Based on symptomatology (daily sputum, cough, shortness of breath aggravated by exertion, and wheezing), employment history (28 years coal mine employment, all underground, working as a shuttle car operator, a miner helper, and operating other equipment, quitting in 1999), individual history (hypertension and hemoptysis on several occasions with respiratory tract infections), family history (heart disease and obstructive airway disease), physical examination (diminished breath sounds bilaterally), smoking history (25 years at a rate of 1 pack per day, and continues to smoke), chest x-ray (1/2)**,** PFT (normal), and an ABG (mild resting arterial hypoxemia), Dr. Baker diagnosed coal worker's pneumoconiosis based on the x-ray and coal dust exposure; mild restrictive arterial defect based on the ABG, and chronic bronchitis based on history of symptoms. Also, Claimant's FEV 1 and FVC were 80% of predicted. Therefore, according to Dr. Baker, Claimant suffers from a Class 1 impairment based on the Guides to the Evaluation of Permanent Impairment, 5th Edition. He also found that Claimant suffered a second impairment based on Section 5.8, pg. 106 of the guide. He explained that the guide concludes that persons with conditions such as Claimants should limit further exposure to coal dust. Dr. Baker opined that the guide "implies" that the Claimant was 100% occupationally disabled. Considering Claimant's 28 year exposure to coal dust, Dr. Baker

[14] Dr. Fino reviewed this ABG study. (EX 8). While he found no significant hypoxemia or significant impairment in oxygen transfer that would prohibit Claimant from returning to his last mining job, and concluded that the exercise oxygenation was normal, Dr. Fino did not make this conclusion based on the July 11, 2001 ABG study alone, but made it in conjunction with two other studies. Since his interpretations of the February 24, 2001 and August 16, 2001 studies are not admissible under the limitations of §725.414 (a)(3), his conclusion based on all three ABG studies is also not admissible. But, in the deposition on December 8, 2003, he testified specifically to the February 24, 2001 ABG study, finding it to be normal. (EX 18: 9).

[15] Dr. Vuskovich stated that Claimant's resting exercise ABG results showed mild hypoxemia with normal response to exercise. He added, however, that since the post exercise ABG blood sample drawn 15 minutes after exercise, it must also be considered a resting study. (EX 12).

opined that there was no other condition to account for the x-ray findings. As a result, Dr. Baker concluded that these impairments were caused by coal dust exposure and cigarette smoking.

Dr. Imtiaz Hussain, an internist and pulmonologist, examined the Claimant on October 31, 2001. (DX 13-16; CX 2). Based on symptomatology (sputum, wheezing, dyspnea, and cough), employment history (28 years as a coal miner), individual history (high blood pressure), family history (high blood pressure and heart disease), smoking history (24 years at 1 pack per day, and continues to smoke), physical examination (illegible), chest x-ray (2/3), PFT (normal), ABG (hypoxemia), and an EKG (normal), Dr. Hussain diagnosed pneumoconiosis due to dust exposure. Based on the x-ray results and Claimant's history of dust exposure, Dr. Hussain opined that this moderate impairment was caused by coal dust exposure. Also, Dr. Hussain did not list cigarette smoking as a possible etiology of Claimant's condition. Finally, Dr. Hussain concluded that Claimant retains the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment.

Dr. David M. Rosenberg, an internist, pulmonologist, and B-reader, examined the Claimant on August 16, 2001 and again on September 17, 2003, and submitted a medical narrative report on September 26, 2003. (EX 2, 10). His August 16, 2001 medical report revealed the following: symptomatology (breathing difficulty, shortness of breath, cough, sputum, and wheezing), employment history (28 years coal mine employment ending in 1999, performing as a shuttle car operator, a continuous miner operator, and most recently operating a light-house which required minimal light work), individual history (hypertension), family history (heart disease and breathing problems), smoking history (one pack per day from age 24 to age 54, cutting down to ½ pack per day at age 55, but continues to smoke), physical examination (equal expansion of the chest with decreased breath sounds, no rales, rhonchi, or wheezes), chest x-ray (negative), PFT (no restriction present pre or post-bronchodilator, and no obstruction post-bronchodilator; the rest of the results were unusable), ABG, and an EKG (nonspecific T wave changes, but otherwise normal).

Dr. Rosenberg's September 26, 2003 report included the following findings: symptomatology (breathing difficulty, shortness of breath, cough, sputum, wheezing, ankle swelling, and resting chest pains), employment history (30 years coal mine employment ending in 1999, with his last six to seven years serving as a light-house attendant), individual history (hypertension), family history (unchanged), smoking history (one to one and a half packs per day from age 22 to age 54, quitting in December 2002), physical examination (normal), chest x-ray (negative), PFT (normal), ABG (preserved oxygenation with an elevated carboxyhemoglobin level), and an EKG (normal).

Dr. Rosenberg concluded that after looking at all of the combined evidence from the two examinations that Claimant does not have the interstitial form of CWP. Also, he concluded that Claimant does not have restriction or obstruction based on a normal diffusing capacity measurement. He opined that any minimal reduction of PO2 probably relates to ventilation/perfusion (CQ) mismatch secondary to his long history of smoking, plus increased weight. Also, with the normal PFT results, Claimant does not have COPD, and he attributed any cough or sputum production to smoking. Finally, Dr. Rosenberg stated that Claimant clearly has no impairments which would prevent him from performing his precious coal mining job or other similarly arduous types of labor.

Dr. Rosenberg was deposed by the Employer on November 8, 2003, when he repeated the findings of his earlier written report. (EX 17).

Hospitalization Records and Treatment Notes

Claimant submitted a letter from Dr. Baker dated October 15, 2002. (CX 1). The letter stated that he had seen Claimant on August 1, 2002 and October 14, 2002, and that the x-ray changes were consistent with pneumoconiosis, category 1/2. He also stated that the PFT and ABG studies revealed normal values. Furthermore, Dr. Baker reiterated his diagnosis of chronic bronchitis, and stated that Claimant continues to smoke. Next was a progress note dated April 1, 2003, where Dr. Baker marked that Claimant continued to suffer from CWP and recommended that he continue his current regimen of medications.

Treating Physician

At the hearing, Claimant testified that Dr. Baker had been his treating physician for the respiratory condition, and that he has seen Dr. Baker every three months. (Tr. 26). An administrative law judge may rely upon the well-reasoned and well-documented opinion of a treating physician as substantial evidence in awarding that physician's opinion controlling weight based upon four factors: (1) nature of relationship; (2) duration of relationship; (3) frequency of treatment; and (4) extent of treatment. § 718.104(d) (2002). "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v.Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988).

In Dr. Baker's February 2001 report, he marked the examination as an evaluation request and not a treatment record. (DX 12). Also, Dr. Baker's treatment note revealed that he had treated Claimant two times in 2002 and one in 2003, but there is no record of treatment prior to August 2001. (CX 1). Therefore, despite his status as treating physician in 2002 and 2003, I find that he was not a treating physician, but merely an examining physician in February 2001. As a result, I do not consider Dr. Baker's diagnosis substantial evidence and do not award his opinion either controlling or any additional weight based solely on his status as a treating physician.

Smoking History

At the July 2, 2001 deposition Claimant testified that he smoked ½ to one pack per day for the last 24 years. (DX 26). He reiterated this history in his response to Employer's

subsequent interrogatories. (DX 27). At the hearing, however, Claimant testified that he smoked for 25 years, one pack on weekend days and ½ packs on weekdays, but quit approximately one year prior to the hearing. (Tr. 19). Dr. Baker reported that Claimant smoked for 25 years at a rate of one pack per day, and continued to smoke at the time of his 2001 examination. (DX 12). In his letter dated October 15, 2002, Dr. Baker stated that Claimant was still smoking, but made no reference to rate. (CX 1). Dr. Hussain reported that Claimant smoked for 24 years at a rate of one pack per day, and continued to smoke the time of his 2001 examination. (DX 13). Dr. Rosenberg reported that Claimant smoked 32 years at a rate of one to one and ½ packs per day, but quit in December 2002. (EX 10).

According to the evidence in the record, Claimant's smoking history falls somewhere between a minimum of 24 years of smoking, according to his testimony, (Tr. 26), to a maximum of 32 pack years, based on the report by Dr. Rosenberg. (EX 10). I presume that the Claimant would not purposely overstate his smoking history, thereby presenting a possible detriment to his own case. As a result, I find Dr. Rosenberg's report as to length of cigarette smoking to be the most persuasive and find that the Claimant has smoked for 32 years, but quit in December 2002. Concerning rate, Claimant states ½ to 1 pack per day, Drs. Baker and Hussain state 1 pack per day, and Dr. Rosenberg states 1 to 2 packs per day. As a result, I find that one pack of cigarettes per day is consistent with all reports. Therefore, I find that Claimant has a 32 pack year history of cigarette smoking, but quit in December 2002.

DISCUSSION AND APPLICABLE LAW

Mr. Roberts' claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record contains eight interpretations of four chest x-rays, and one quality-only interpretation. Dr. Baker interpreted the February 24, 2001 film as positive for pneumoconiosis. Dr. Wiot, a physician dually-certified as a radiologist and B-reader, interpreted the film as negative for pneumoconiosis. I accord greater probative weight to the negative interpretation of

Dr. Wiot in comparison to the contrary interpretation of Dr. Baker based on Dr. Wiot's superior credentials. Therefore, the February 24, 2001 film is negative for pneumoconiosis.

Dr. Hussain interpreted the July 11, 2001 film as positive for pneumoconiosis. Dr. Poulos, a physician dually-certified as a radiologist and B-reader, interpreted the film as negative for pneumoconiosis. I accord greater probative weight to the negative interpretation of Dr. Poulos in comparison to the contrary interpretation of Dr. Hussain based on Dr. Poulos' superior credentials. Therefore, the July 11, 2001 film is negative for pneumoconiosis.

Dr. Poulos interpreted the August 16, 2001 film as negative for pneumoconiosis. Dr. Alexander, a radiologist and B-reader, read the film as positive for the disease. Dr. Poulos then conducted a rehabilitative re-reading of the x-ray and again found it to be negative. Based on the fact that Drs. Poulos and Alexander are equally credentialed x-ray interpreters, I find the film to be inconclusive for the presence of pneumoconiosis. Therefore, the August 16, 2001 film does not establish the presence of pneumoconiosis by a preponderance of the evidence.

Dr. Rosenberg, a B-reader, interpreted the September 17, 2003 chest x-ray as negative for pneumoconiosis. There were no positive readings. Therefore, I find the September 5, 2003 film to be negative for the pneumoconiosis.

I have determined that three of the four of the x-rays in evidence are negative for pneumoconiosis, and that the fourth x-ray is inconclusive. Also, the most recent film was interpreted by a B-reader to be negative for the disease. As a result, I find that the preponderance of the chest x-ray evidence establishes that there is no pneumoconiosis. Therefore, I find that Claimant has failed to establish the presence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary

> function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

The evidentiary record contains four narrative medical opinions by examining physicians. Dr. Baker examined Claimant, and based on an x-ray and exposure he diagnosed pneumoconiosis; based on the ABG results, he diagnosed mild restrictive arterial defect; and based on history of symptoms, he diagnosed chronic bronchitis. While Dr. Baker set forth clinical observations and findings, I find his reasoning is not supported by adequate data. First, the ABG he relied upon was non-qualifying under Department of Labor standards. Second, concerning chronic bronchitis, an analysis of history of symptoms is not objective. Third, the Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000). The Board has also explained that, when a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc*., 8 B.L.R. 1-405 (1985). See *also Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc*., 12 B.L.R. 1-111, 1-113 (1989)(it is permissible to discredit the opinion of a physician which amounts to no more than a restatement of the x-ray reading). Not only did Dr. Baker base his diagnosis solely on an x-ray and history of dust exposure, but I found the x-ray reading he relied on was re-read as negative by a more qualified reader. Therefore, despite his credentials as an internist and pulmonologist, I find that Dr. Baker's opinion does not constitute a reasoned medical opinion for the purposes of diagnosing pneumoconiosis.

Dr. Hussain determined that based on the chest x-ray and Claimant's history of coal dust exposure, that Claimant was moderately impaired due to pneumoconiosis. The remainder of his objective test results was non-qualifying under DOL standards. Based on the precedent of *Cornett* and *Taylor*, Dr. Hussain's report, despite his credentials as an internist and

pulmonologist, is not a reasoned medical opinion for the purposes of determining the presence of pneumoconiosis under subsection (a)(4).

Unlike Drs. Baker and Hussain, Dr. Rosenberg's medical opinions are supported by the objective data he utilized, including negative x-rays, insignificant clinical examinations, and non-qualifying PFTs and ABG studies, to diagnose that Claimant does not suffer from pneumoconiosis. As a result, I find his reports well-documented and well-reasoned. Bolstered by his credentials as a pulmonologist, internist and B-readers, I accord his conclusions substantial probative weight.

The record contains two reasoned and documented medical opinion by Dr. Rosenberg, both concluding that Claimant does not suffer from clinical or legal pneumoconiosis. Furthermore, even without Dr. Rosenberg's reports, I found that the two medical reports concluding pneumoconiosis were unreasoned. As a result, I find that the Claimant has failed to establish the presence of pneumoconiosis by a preponderance of the evidence under subsection (a)(4).

Claimant has failed to establish the presence of pneumoconiosis under subsection (a)(1)-(4). Therefore, after weighing all evidence of pneumoconiosis together under §718.202 (a), I find that Claimant has failed to establish the presence of pneumoconiosis.

Total Disability

To be entitled to benefits under the Act, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. None of the PFTs produced values equal to or below those found in Appendix B of Part 718. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. None of the ABGs produced produce values that met the requirements of the tables found at

Appendix C to Part 718. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment as a light–house attendant included sitting for five hours per day, standing for five hours per day, and lifting 50 pounds several times per day. (DX 4).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

There are four narrative medical reports in the record, as summarized above. Dr. Baker is the only physician of record to conclude that Claimant is totally disabled due to pneumoconiosis. He based his diagnosis on an x-ray, a non-qualifying ABG, and Claimant's reported history of symptoms. Dr. Baker stated that considering the PFT values, Claimant was 100 % occupationally disabled.[16] He based this determination on his finding that Claimant has a Class 1 impairment as classified in the Guide to Evaluation of Permanent Impairment, 5th Edition.[17] According to Dr. Baker, the guide concludes that persons with pneumoconiosis should limit further exposure to coal dust, and that this conclusion implies that the Miner is 100% disabled from returning to coal mine employment or similar dusty occupations. His rational is that the Claimant should not return to a dusty environment so as not to exacerbate his pneumoconiosis. An opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. *Zimmerman v. Director,*

[16] Dr. Baker's treatment note dated October 15, 2002 states that Claimant's PFT and ABG studies reveal normal values. (CX 1).

[17] Mere designation of a Claimant's pulmonary impairment as a Class I or II impairment does not warrant a finding of total disability under the Act absent a well reasoned and well documented opinion that the standards of the Act have been met.

OWCP, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.,* 12 B.L.R. 1-83 (1988); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Bentley v. Director, OWCP*, 7 B.L.R. 1-612 (1984); *Brusetto v. Kaiser Steel Corp.,* 7 B.L.R. 1-422 (1984). Therefore, Dr. Baker has not accurately addressed whether Claimant's condition prevents him from engaging in his usual coal mine employment or comparable gainful employment under standards mandated by the present Act, but instead has simply recommended that Claimant not engage in these activities. Also, his documentation of limitations on Claimant's residual exertional capacity necessary to perform his duties as a coal miner is virtually non-existent. As a result, despite his qualifications as an internist and pulmonologist, I find that Dr. Baker's conclusion of total disability does not constitute a reasoned and documented medical opinion.

Drs. Hussain, and Rosenberg concluded that Claimant was not totally disabled from a pulmonary standpoint. These physicians are internists and pulmonologist, and their disability conclusions are supported by the objective evidence in the record. As a result, I find that their opinions concerning total disability are well-reasoned and well-documented.

Taken as a whole, the medical narrative evidence does not support a finding of total pulmonary disability. Claimant has not proven by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. Therefore, I find the Claimant has failed to establish total pulmonary disability or total disability due to pneumoconiosis under § 718.204(b)(iv).

Claimant has failed to establish that he is totally disabled under subsection (b)(i)-(iv). Therefore, after weighing all evidence concerning total disability under §718.204 (b), I find that Claimant has failed to establish that he is totally disabled due to pneumoconiosis.

Entitlement

Claimant, Doyle Roberts, has failed to establish either the existence of pneumoconiosis under §718.202(a) or total disability under § 718.204(b)(2). Therefore, I find that Mr. Roberts is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Doyle Roberts for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**